

Patient Consent for
Use and Disclosure of Health Information

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By signing, I authorize Sirota Chiropractic Center to use and/or disclose my protected health information (PHI) to carry out treatment, payment activities and healthcare operations.

I understand I have the right to read the Notice of Privacy Practices before I decide whether to sign this Consent. The Notice provides a description of treatment, payment activities, and healthcare operations, the uses and disclosures Sirota Chiropractic Center may make of my protected health information, and of other important matters about my protected health information. A copy of the Notice accompanies this Consent and I am encouraged to read it carefully and completely before signing this Consent.

I understand that Sirota Chiropractic Center reserves the right to change their privacy practices as described in the Notice of Privacy Practices. If they change their privacy practices, they will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of my protected health information that they maintain.

I understand that at any time I may obtain the most recent version of the Notice of Privacy Practices by contacting:

Contact Officer: **Dr. Jonathan A. Sirota**

Telephone: **914-437-8781**

Fax: **914-437-8783**

Email: Doc@DrSirota.com Address: P.O.Box 340628 Brooklyn, N.Y. 11234

I understand that I have the right to refuse to sign this consent. Sirota Chiropractic Center will not condition my treatment (and, if applicable, payment for my health care or eligibility for benefits) on whether I provide authorization for the requested use of disclosure – except in limited circumstances. (e.g. if the treatment is research-related or is necessary for the purpose of creating protected health information for disclosure to a third party.)

I understand that I have the right to revoke this Consent in writing by sending my revocation to the Contact Officer listed above. I understand that revocation of this Consent will not affect any action(s) taken by Sirota Chiropractic Center before they received my written revocation.

I understand this authorization will expire on: 01/01/2099

I, _____, have had full opportunity to read and consider the content of this Consent and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information in order to carry out treatment, payment activities and health care operations.

Signed by: _____
Signature of Patient or Legal Guardian Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.